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ABSTRACT

Although research on homosexuality has utilized psychiatric patients as subjects, few studies have examined the use of homosexuality as a psychiatric diagnosis. Using the Diagnostic and Statistical Manual of Mental Disorders (DSM) definition of homosexuality as a psychiatric disorder only when homosexuality is ego-dystonic, an intensive review of the psychiatric records of 26 women diagnosed as homosexual was conducted. Demographic variables, clinical information, other diagnoses, and treatment procedures were examined. Patients were classified as either dystonic, experiencing a developmental crisis, being a legal referral for sexual conduct, or being concerned with other problems. The relationship of the homosexuality diagnosis to the actual presenting problem was rated as either directly related, partially related, unrelated, or not supported. Data analyses suggested that none of the 26 patients formally diagnosed as homosexual fit the DSM criteria for sexual orientation disturbance, and most had predominant psychiatric concerns other than sexuality. Homosexuality was inappropriate as a primary diagnosis for one-third of the sample, and of questionable relevance as a secondary diagnosis for the rest. These findings question the use of homosexuality as a diagnosis. (NRB)

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# THE USE OF HOMOSEXUALITY AS A PSYCHIATRIC DIAGNOSIS FOR WOMEN

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Paper presented at the Annual Conference of the Association for Women in Psychology, Boston, MA, March 5-8, 1981.

The Use of "Homosexuality" As A
Psychiatric Diagnosis for Women

Although research on homosexuality has traditionally utilized psychiatric patients as subjects, little has been done to examine the use of homosexuality as a psychiatric diagnosis. In 1973 the American Psychiatric Association voted "to eliminate Homosexuality per se as a mental disorder and to substitute . . . a new category titled Sexual Orientation Distrubance" (DSM II, 1974). This vote thereby narrowed the concept of homosexuality as a psychiatric disorder as applicable to only those "individuals whose sexual interests are directed primarily toward the same sex and who are either disturbed by, in conflict with, or wish to change their sexual orientation."

More recently, the new DSM III (1980) has specified that the diagnosis of homosexuality may only be assigned when it is "ego-dystonic", that is, the "pattern of overt homosexual arousal . . .has been unwanted and a persistent source of distress." A critique of this diagnostic category will be offered later. For now, it is of interest to determine how the DSM II diagnosis of Sexual Orientation Disturbance has been used.

In an earlier study (Shachar and Evenson, in press), I used the automated data-base of the Missouri Department of Mental Health, consisting of approximately 300,000 clinical records of patients served from 1970-79, to identify all those patients given a DSM II diagnosis of homosexuality (302.0). Three-hundred-fifty-nine patients were identified (or 0.1% of the total

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population)--eighty-three percent of which were male. Of these patients, 98 were served by a large urban community mental health center in St. Louis. Today's presentation concerns the data gathered in an intensive review of the psychiatric records of the 26 women in this sample.

Method

Using a standard recording form devised for this study, two raters (including myself) reviewed the written patient records for demographic and clinical information. Although only one of the 26 patients continues to receive services at the facility, subjects' confidentiality was protected by using only case numbers to identify coding forms, and all names were deleted when transcribing narrative information.

The following data were collected:

-demographic variables (age, race, education, etc.)

-clinical information, such as the presenting complaint, symptoms, and psychiatric history.

-other DSM II diagnoses assigned to the patient.

-treatment prescribed and administered.

Based soley upon the information provided by the CMHC staff in the patient's record, raters informally diagnosed the patient as belonging to one of four types:

1) dystonic regarding their homosexuality, that is, experiencing discomfort with being gay (and whether the discomfort appeared to stem from their own feelings or from outside pressures, such as family).
2) in a developmental crisis, such as experiencing homosexual feelings during adolescence.
3) a legal referral for sexual conduct.
4) largely concerned with other problems, such as depression or alcoholism.

We also rated the relationship of the formal DSM II diagnosis of homosexuality to the actual presenting problem as belonging to one of four categories:

1) directly related (e.g., patient explicitly says she is unhappy with being gay and seeks treatment for that reason)
2) partially related or incidental (e.g., patient complains of depression with onset following the breakup of a lesbian relationship)
3) totally unrelated (e.g., patient complains of hearing voices, and also happens to be gay)
4) not supported in record -- we found no mention of a homosexual relationship or identity in the record to suggest this diagnosis

The raters agreement on 6 of the 26 cases was 100% for all demographic variables except marital status (83%) and occupation (66%). For both the informal diagnosis and the assessment of the relationship between the formal DSM II diagnosis and the presenting problem, raters were in agreement 83% of the time.

Results and Discussion

As seen in Table 1, the 26 women served by this CMHC and given a diagnosis of homosexuality were predominantly young (mean age = 27.0) with a high school education. None of the women held professional jobs, but were somewhat evenly divided among the service-domestic, labor, and unemployed categories. Two-thirds were white, and slightly less than half had been heterosexually married. (Two women reported that their marriages were either for purposes of convenience, i.e., married gay men, or for economic support.) Half of the sample had children. Eighty-five percent were seen on an outpatient basis.

Disappointingly little information was found in clinical records regarding treatment prescribed and administered, exacerbated by the fact that 11 (42%) of the patients were seen once and never returned for aftercare appointments. Eight of these "no shows" were admitted for depression and given medication and/or referred to the outpatient clinic. A more indepth analysis of why these patients do not return for treatment would be helpful, although dropout rates tend to be high for outpatient psychiatric populations in general (Garfield, 1980).

Of the treatment documented, medication was the most commonly prescribed (58%) and administered (42%). We could be certain of only 4 cases receiving psychotherapy. Furthermore,

only in one 1973 case did a physician refer to treating the patient's homosexuality, wherein he noted that for this married, depressed woman with a primary diagnosis of homosexuality:

> It is not clear... if her deviant sexual behavior is a definite source of distress to the patient. She has been practicing homosexuality over a long period of time and has been comfortable with it, except on sporadic occasions. This does not seem to be an acute problem...it is also highly unlikely that any of the measures that may be employed to "treat" her homosexuality would attain success.

It is curious that this is the only mention of therapeutically addressing a patient's homosexuality when the diagnosis was not only used in every one of the 26 cases, but was also the sole diagnosis for one-third of the sample, as seen in Table 2. It is possible that the psychiatrists' intent in these cases was to use the diagnosis for purposes of description rather than for treatment.

When we further examined the eight patients who received no diagnosis other than homosexuality, five were so diagnosed after 1973. Of these, only two were experiencing discomfort with their sexual orientation. Moreover, both were clearly due to family pressures. For example, one record states:

> Patient's mother found out last weekend that patient was gay, told her she was grossly abnormal and had to see a psychiatrist. Patient does not think she is abnormal, but thinks society does not accept her. She is satisfied with her current relationship.

One other record gave insufficient information to diagnose the patient. The two remaining patients were depressed, or abused alcohol. Thus, out of the five cases so diagnosed, none fit

the criteria for the DSM II Sexual Orientation Disturbance category since they expressed no wish to change their sexual orientation.

When patients were informally diagnosed by raters (see Table 3) as dystonic, developmental crisis, legal referral, or other concerns, we found none that fit the developmental and legal categories. Three patients fit the category of dystonic, that is, they experience problems with their sexual orientation, but all of these were related to outside pressure, such as the case cited earlier.

The remaining 88% of the cases were felt to be more appropriately diagnosed as primarily related to "other" clinical concerns, of which depression accounted for 60%. Thus, very few cases were thought to be clinically concerned with homosexuality, and those that were, in actuality, concerned the reactions of homophobic others.

Raters also assessed the relationship of the formal homosexual diagnosis to the actual psychiatric problem using four categories: 1) Directly related, 2) Partially related or incidental, 3) Totally unrelated, and 4) No support of the diagnosis. The same percentage (88%) of cases informally diagnosed as "other" concerns were also rates as partially-related, incidental, or totally unrelated to the patient's problem.

An example of a partially-related case is that of a 20 year old woman, separated, with two children, who was admitted with a primary diagnosis of Depressive Neurosis and symptoms of "moderate to severe depression." She was living with her lesbian lover for

the past year. While her depression was the primary psychiatric concern, it seems to be related to: 1) her fear that her 5 year old son might come to resent her sexual orientation; 2) her son appeared to prefer her lover; 3) the patient's lover was involved with another woman; and 4) the patient felt she must hide her relationship with her lover.

Her sexual orientation was a concern for this patient and a secondary diagnosis of homosexuality was technically appropriate in 1973. But she did not express dissatisfaction with being gay. Coping skills for dealing with her situation or an exploration of the appropriateness of this relationship would seem to be indicated rather than therapy focused on her homosexuality, per se.

The following case illustrates an <u>incidental</u> relationship between the DSM II homosexual diagnosis and the presenting problem: A 35 year old woman, divorced with 4 children was mildly intoxicated and depressed when she came to the emergency room of the CMHC saying "My girlfriend is giving me problems." The record stated that the patient was living with her lover for the past two-and-one-half years and was upset that her lover went out with her ex-husband. No dissatisfaction was expressed by the patient regarding her homosexuality. This case was rated as <u>incidental</u> in the relationship of the homosexual diagnosis to the problem, since a heterosexual with the same presenting problems would be diagnosed for depression, not her sexual orientation.

The following case is illustrative of a diagnosis of homosexuality which was felt to be <u>totally unrelated</u> to the presenting problem: a 42 year old single woman came to the CMHC with

depression and anxiety. The screening note reports her history as "living by herself (for the last 22 years)... in and out of mental hospitals for short and long periods." This patient was formally diagnosed as schizophrenic. The social service report states:

> "(patient) said she has always been homosexual and felt guilty about it until (15 years ago) when she resolved her feelings. . . For the last seven or eight years she has chosen to be celibate because she does not want to cope with society's attutudes toward homosexuals. She says this area of her life is not a problem to her. She feels her hospitalizations occur when relationships terminate and she isolates herself."

Thus, her psychiatric problems concern her schizophrenia and social isolation, rather than her homosexuality.

A surprising number of records mentioned physical and sexual abuse in the psychiatric history. Twenty-three percent (6) of the women reported being victims of incest. Three women (12%) were battered in heterosexual relationships, and an equal number were either battered (2) or the batterer (1) in their lesbian relationships. (Without a matched control group of heterosexual female patients it is impossible to assess whether this high rate of reported abuse is true of female psychiatric patients in general, those diagnosed as homosexual in particular, or is simply idiosyncratic to this sample. Insufficient data are available in the prevalence of sexual abuse in the psychiatric histories of patients, although Katz and Mazur (1979) review four studies which suggest a rate of 2 to 5% for female psychiatric patients with a history of incest.)

Thus, we found that none of the 26 female psychiatric patients formally diagnosed as homosexual fit the criteria for

Sexual Orientation Disturbance, and most had predominant psychiatric concerns other than their sexuality. The label was inappropriate as a primary diagnosis for one-third of the sample, and of questionable relevance as a secondary diagnosis for the rest.

Should homosexuality be used as diagnosis? I am inclined to agree with Robert Stoller, M.D., who -- in a 1973 symposium entitled, "Should Homosexuality Be In The APA Nomenclature?" (1973) -- stated that homosexuality does not qualify as a diagnosis. To qualify as a diagnosis there should be:

1) A <u>syndrome</u> - a collection of signs and symptoms shared by a group of people - and in this case there is only a sexual preference;

2) <u>Underlying dynamics</u> - and different homosexuals have different psychodynamics underlying their sexual behavior- as do heterosexuals;

3) <u>Etiology</u> - very different life experiences can cause the psychodynamics and behavior of different homosexuals.

DSM III is not concerned with underlying dynamics or etiology; rather the diagnoses are based on more objective, observable criteria. Thus, the diagnosis of Ego-Dystonic Homosexuality does not attempt to explain homosexuality, but addresses those homosexuals who do not wish to be. It is to the credit of the authors of this romenclature that they caution that the category "should be avoided in cases where the desire to change orientations may be brief, temporary manifestation of an individual's difficulty in adjusting to a new awareness of his or her homosexual impulses."

They also acknowledge that "the factors that predispose to Ego-dystonic Homosexuality are those negative social attitudes toward homosexuality that have been internalized." "In addition," they continue, "features associated with heterosexuality, such as having children and socially sanctioned family life, may be viewed as desirable and incompatible with a homosexual arousal pattern." For these reasons, DSM II is a vast improvement in the diagnostic nomenclature concerning homosexuality.

This study's findings and the changes in diagnostic nomenclature have at least two implications for educating mental health professionals. First, when a psychiatric label is applied, it should be done so appropriately, that is, as the result of a match between the patient's symptoms and the diagnostic criteria, rather than as a description of the patient when it is irrelevant to the problem. Lesbians are, no doubt, reluctant to seek mental health services when their homosexuality is the focus, rather than their presenting complaints.

And second, mental health professionals should be educated regarding the impact of socialization and a homophobic society that lead Lesbians to experience discomfort with being gay. When Lesbians do present their homosexuality as a psychiatric concern, it is essential to ferret out how much of their discomfort is generated by a homophobic society, and how much is ego-dystonic (though I believe these two cannot be mutually exclusive).

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TABLE I

Demographic and Descriptive Variables of 26 Female Psychiatric Patients Given DSM II Homosexual Diagnosis (302.0)

| Age | N | (%) |
|---|---|---|
| 0-19 | 3 | (12) |
| 20-29 | 16 | (62) |
| 30-39 | 5 | (19) |
| 40-49 | 2 | ( 8) |
| $\bar{x}$ = | 27.0 | |

| Occupation | | |
|---|---|---|
| Professional | 0 | ( -) |
| Service/ Domestic | 7 | (27) |
| Operative, Labor, Housewife | 10 | (38) |
| Unemployed | 9 | (35) |

| Patient Status | | |
|---|---|---|
| Inpatient | 4 | (15) |
| Outpatient | 22 | (85) |

| Race | N | (%) |
|---|---|---|
| White | 16 | (62) |
| Non-white | 10 | (38) |

| Marital Status | | |
|---|---|---|
| Never Married | 14 | (54) |
| Married | 1 | ( 4) |
| Divorced or Separated | 11 | (42) |

| Education | | |
|---|---|---|
| 8 years | 6 | (23) |
| 9-12 years | 15 | (58) |
| 13+ years | 3 | (12) |
| Missing information | 2 | ( 8) |
| $\bar{x}$ = | 10.8 | (years) |

TABLE 2

Associated Diagnoses Assigned to 26 Female Patients
Diagnosed Homosexual (302.0, DSM II)

| | Primary | Secondary | Total N | Total (%) |
|---|---|---|---|---|
| Major Affective Disorders | | | | |
| Manic-depressive, depressed | 3 | 2 | 5 | (19) |
| Other | 1 | 2 | 3 | (12) |
| Depressive Neurosis | 3 | | 3 | (12) |
| Alcohol-Drug Abuse | 2 | 1 | 3 | (12) |
| Adjustment Reaction | 1 | | 1 | ( 4) |
| Personality Disorder | 1 | | 1 | ( 4) |
| Schizophrenia | 1 | | 1 | ( 4) |
| Other Sexual Deviation | | 1 | 1 | ( 4) |
| No Diagnosis other than "Homosexuality" | | | 8 | (31) |
| | | | 26 | (100) |

TABLE 3

Rater's Informal "Diagnosis" Based on Presenting Problem

| "Diagnosis" | N | (%) |
|---|---|---|
| Dystonic Homosexuality | | |
| Self | 0 | ( -) |
| Outside Pressure | 3 | (12) |
| Developmental Crisis | 0 | ( -) |
| Legal Referral | 0 | ( -) |
| Other: | 23 | (88) |

| | N | ( %) |
|---|---|---|
| Neurotic Depression | 10 | (43) |
| Affective Disorder - depression | 4 | (17) |
| Alcohol/Drug abuse | 5 | (22) |
| Adjustment Reaction | 3 | (13) |
| Personality Disorder | 2 | ( 9) |
| Schizophrenia | 1 | ( 4) |
| No information | 2 | ( 9) |

TABLE 4

Rater's Assessment of the Relationship of Formal Diagnosis of Homosexuality (302.0) to Psychiatric Problem

| Relationship | N | (%) |
|---|---|---|
| Directly related | 1 | ( 4) |
| Partially Related or incidental | 11 | (42) |
| Totally unrelated | 12 | (46) |
| No support for diagnosis | 2 | ( 8) |